Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10/31/11
Amount 2100.00

#16883

Carespring Leasing, LLC

I. IDENTIFICATION

Name: Highlandspring of Ft. Thomas

Address: 900 Highland Ave.

City/County/Zip: Ft. Thomas. Ky Campbell Co. 41075

Telephone number: 859. 572. 0660 amyta@carespring.com

Administrator: Amy E. Thompson

Date facility operation began at current address: 9.1.93

Date facility began operation under current owner: 9.1.93

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	140	
Nursing Home		
Nursing Facility		
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	✓Profit	Individual
County	Nonprofit	Partnership
City		✓Corporation
✓Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Barry Bortz CEO 390 Wards corner Rd. Loveland OH
David Eppers CFO 390 Wards corner Rd. Loveland OH 45140

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation High Day Inc.

Address of corporation 390 Wards Corner Rd. Loveland, OH 45140

President or Chairman Barry Bortz, CEO

Vice President David Eppers, CFO

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Michelle Wilson — Admin Asst. — 9-23-11

Signature of authorized representative | Title | Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)